Business Process Name	Goal	Objective	Business Rules	Trigger(s)	Task Set	Inputs	Outputs	(Measurable) Outcomes
Definitions	The major health goal that the business process supports. The goal is the end state to be achieved by the work of the health agency and should be defined in terms of the benefits provided to the community/population or individual/client	A concrete statement describing what the business process seeks to achieve. The objective should be specific to the process such that one can evaluate the process or reengineer the process and quantify performance measures. A well-worded objective will be SMART (Specific, Measurable, Attainable/Achievable, Realistic and Time-bound).	A set of criteria that defines or constrains some aspect of the business process. Business rules are intended to assert business structure or to control or influence the behavior of the health agency (business).	Event, action or state that initiates the first course of action in a business process. A trigger may also be an input, but not necessarily so.	The set of activities that are carried out in a business process.	Information received by the business process from external sources. Inputs are not generated within the process.	Information transferred out from a process. The information may have been the resulting transformation of an input, or it may have been information created within the process.	The resulting transaction of a business process that indicates the objective has been met. Producing or delivering the outcome satisfies the stakeholder of the first event that triggered the business process. Often, measures can be associated with the outcome (e.g., how much, how often, decrease in incidents, etc.). Please note that an outcome can be, but is not necessarily, an output of the process.
1. Data Management	Chronic disease, risk factors, and related public health data are managed (collected, processed, retrieved) to maintain confidentiality, integrity and quality.	a. To provide adequate infrastructure to manage chronic disease data b. To collect and process data according to accepted standards and methods c. To retrieve timely data that fulfills program reporting needs	a. Protocols for data collection, management and confidentiality b. Laws, regulations, policies and procedures c. IRB approval d. Data sharing agreements	Program need for data	a. Determine data structure requirements b. Develop database system c. Determine data retrieval requirements d. Identify & acquire access to data e. Develop data retrieval system f. Maintain quality of data g. Maintain database integrity & confidentiality h. Maintain integrity of database links i. Data collection j. Data validation k. Cleanse data	a. Methodologies for collecting data and evaluating quality b. Data management guidelines c. Resources (funding, programmers, equipment) d. Program data element requirements e. Available data	a. Relational database structure manual b. Programming integrity log c. Data entry tools d. Client information tools e. Provider tools f. Data quality reports g. Program quality reports h. Ad hoc reporting tools	a. Database infrastructure that is cost effective to manage and modify b. Data managed according to accepted standards and methods c. Data retrieval that is timely, efficient, and accessible

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2. Disease Status and Burden Assessment	Chronic disease status and burden are readily assessed using methods and an information system that provides current, accurate, and accessible data.	To publish timely and useful status and burden reports	a. Assessment statistical methods b. Assessment report guidelines	a. Grant requirements b. Assessment requests c. Identified or perceived burden	a. Act on request for scheduled or special request for assessment b. Define target population c. Determine analytic methods and parameters d. Develop assessment plan e. Collect prevalence data f. Analyze and interpret data g. Identify issues and concerns h. Prepare assessment report(s) i. Disseminate report(s)	a. Recommend-ations from prior assessments b. Chronic disease and risk factor data and population demographics c. National and state goals/benchmarks /guidelines d. Identified or perceived burden	a. Assessment and burden reports b. Dissemination plan	Published Health Status and Burden Report
3. Policy, Standards and Regulations {Essential Services 3, 4, 5}	Policies, standards and regulations impacting chronic diseases are anchored in current evidence-based science and standards.	a. To convene education sessions for policy makers, stakeholders and partners on current statistics, evidence based science and standards related to chronic disease b. To implement public health policies, standards and regulations for chronic disease prevention and management based on evidence and standards	a. Funder/payer reimbursement guidelines b. Legislation or executive orders c. Regulations, policies and procedures	a. Standards b. Mandates c. Surveillance data	a. Identify evidence-based standards & practices b. Conduct community environment assessment c. Develop strategic plan d. Develop education & advocacy plans and supporting materials e. Respond to new decision items, fiscal notes f. Recommend new policy, regulations, standards g. Mobilize partners & stakeholders for policy support h. Educate policy makers & promote proposed policies and legislation i. Evaluate process effectiveness	a. Evidence based practices and standards b. Epidemiological research and disease status assessments c. Public health policy recommendations from federal and national sources	a. Guidelines for chronic disease management b. State health, health financing and health legislation status reports c. Standards and regulations d. Model policies	a. Increased number of public health education sessions for policy makers, stakeholders and partners on current statistics, evidence based science and standards related to chronic disease. b. Increased percentage of new chronic disease policies, standards and regulations based on current evidence based science and standards.

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4. Program Administration	Chronic disease programs are successfully administered through planning, managing and improving program components as well as training staff and partners.	a. To develop an integrated strategic plan that addresses targeted disease of program b. To increase program participation c. To reduce program cost per output d. To increase competencies of partners and staff	a. Grant/funder guidelines and protocols b. Laws, regulations, policies and procedures c. Standards	a. New funding opportunities b. Performance reviews c. Laws, executive orders, directives, regulations, budgets d. Disease status and burden assessment	a. Conduct strategic planning b. Design program infrastructure c. Obtain funding/resources d. Institute data management e. Train staff and providers, partners when needed f. Institute collaborations across programs and partners g. Implement program h. Manage contracts i. Evaluate program effectiveness and quality j. Report program status k. Redesign program when needed	a. Results of disease status and burden assessment b. Standards and guidelines c. Quality improvement methodology d. National reimbursement codes e. Contractor or provider invoices and reports f. Strategic Plan	a. Strategic, work and training plans and materials b. Executed contracts with clear deliverables c. Payments for services d. Quality and financial reports e. Collaborations established with other programs and partners	a. Integrated strategic plans b. Program participation maintained or increased c. Cost per output maintained or decreased d. Partners and staff demonstrate targeted levels of skills and knowledge
5. Partner Mobilization { Essential Service 4}	Partnerships are established for the purpose of preventing and managing chronic disease.	To mobilize partners to establish and maintain programs and services for prevention and management of chronic diseases	a. Partnership composition guidelines from grants/laws b. Regulations, policies, and procedures for engaging partners	Identified need for new or changes to partnerships to assist in implementing programs and/or services	a. Recruit key stakeholders in chronic disease prevention and control b. Convene and facilitate partnership meetings c. Identify set tasks for partnership(s) to accomplish d. Recruit healthcare providers e. Institute contracts when needed f. Deliver services based on standards of care g. Assess partnerships/ providers to identify mobilization gaps/barriers and strengths/weaknesses	a. Chronic disease data b. Current social marketing techniques c. Standards and guidelines d. Official and stakeholder recommendations e. Partner capacity, vision and mission	a. Partnership agreements, statewide plans and reports b. Established networks c. Public policies, programs and services to prevent chronic disease	Chronic disease programs and services are established and implemented utilizing partnerships

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6. Prevention, Control and Self-Management Education	Chronic Disease Programs collaborate with partners to provide chronic disease education on prevention and control methods and evidence-based self-management practices in order to reduce the incidence of, complications from, and associated risk factors for, chronic diseases.	a. To increase the number of prevention, control, and self-management educational opportunities in the community b. To increase the number of payers that reimburse for education c. To increase the number of healthcare professionals & Missourians using best practices for prevention, control, and self-management d. To decrease the number of disabilities and complications related to chronic diseases.	a. National standards of care and practice guidelines b. Laws & regulations c. Departmental processes and procedures d. Grant/funder guidelines e. Payer reimbursement guidelines f. Administrative/ legislative directives	Identified need for chronic disease prevention, control and self-management education services	a. Identify/assess community needs b. Identify evidence-based or promising prevention, control and self-management practices c. Develop new or modify existing education programs, strategies, tools d. Develop marketing, strategies and agreements for services e. Deliver training tools for partners/providers f. Develop evaluation tools g. Develop & mobilize partnerships h. Deliver program services & trainings i. Evaluate program services	a. Standards & guidelines b. Disease status and burden assessment c. Evidence-based intervention programs and services	a. Service agreements b. Deliverable interventions and services c. Evaluations and reports	a. Increased number of CD prevention, control and self-management programs in the community b. Increased number of payers reimbursing for chronic disease education c. Increased number of healthcare professionals & Missourians using best practices for prevention, control, and self-management of chronic diseases d. Decreased number of disabilities and complications related to chronic diseases
7. Screening and/or Risk Identification (Note: Linked to EPHS 3,7 and 8)	Missourians are knowledgeable about and demonstrate behaviors that prevent and/or control chronic diseases.	a. To increase the numbers of Missourians participating in behaviors that reduce the risk of chronic diseases b. To increase the numbers of Missourians who receive	a. Grantor/funder guidelines b. Standards c. Laws, regulations, policies and procedures d. Payer reimbursement guidelines e. Capacity requirements for providers	a. Mandates b. Identified need for screening and/or risk identification interventions	a. Identify evidence-based and evidence-influenced screening and/or risk identification interventions and strategies b. Maintain active advisory committee c. Develop new or modify existing program per funder guidelines	a. Standards and guidelines b. Available data c. Partner recommendations	a. Directory of service providers b. Provider guidelines c. Educational materials for the public	a. Increased number of Missourians participating in healthy behaviors b. Increased number of Missourians receiving screenings c. Increased number of service providers d. Increased early detection of chronic

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7. Screening and/or Risk Identification (cont.)		recommended screenings c. To increase the number of providers of chronic disease prevention services d. To increase the early detection of chronic diseases and referrals into early treatment			d. Recruit providers & institute agreements e. Develop reimbursement training tools f. Design QA reviews and monitoring g. Provide case management services focused on early detection h. Collect data, evaluate services/providers i. Prepare and disseminate reports			diseases
8. Program Evaluation	Chronic disease programs demonstrate accessibility, effectiveness, quality and cost efficiency through evaluation.	a. To evaluate annually the chronic disease programs' processes for accessibility and effectiveness b. To evaluate chronic disease programs for intermediate outcomes of health status and prevention effectiveness c. To evaluate chronic disease programs for cost efficiency	a. Performance and process measurement methodologies b. Laws, regulations, policies and procedures c. Standards d. Data sharing agreements e. Scientific methodology	Internal/External Requests or Requirements	a. Identify and prioritize measures of program and activities to evaluate b. Assess & acquire data resources and prepare evaluation plan c. Develop new or revise existing evaluation plan d. Review plan e. Collect, analyze and interpret data f. Prepare and disseminate evaluation report(s)	a. Program performance and process measures b. Guidelines benchmarks c. Resources (funding, staff, equipment) d. Available data	a. Evaluation plan b. Written evaluation report c. Recommendations for program improvements or changes	a. Increased program accessibility and effectiveness b. Increased intermediate health outcomes c. Increased cost efficiency of programs